TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SOUTH HAMPTON COMMUNITY HOSPITAL

Respondent Name
EAST TEXAS EDUCATIONAL INSURANCE ASSOCIATION

MFDR Tracking Number
M4-14-3650-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
August 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our records indicate that the claim was filed timely to the appropriate billing address. Attached is account notation that establishes initial and subsequent filing. . . . It is our position that we have met our timely filing obligation."

Amount in Dispute: $93,837.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our initial receipt of this bill was 1/22/14 and due to the fact the charges were filed past 95 days, services were denied for timely filing on 2/4/14."

Response Submitted by: Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 27, 2013	Outpatient Hospital Services	$93,837.56	$12,867.42

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
5. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - 719 – PER RULE 133.20, A MEDICAL BILL SHALL NOT BE SUBMITTED LATER THAN THE 95TH DAY AFTER THE DATE OF SERVICE.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Did the health care provider submit the medical before the 95th day after the date the services were provided?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended reimbursement for the disputed implantables?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason codes 29 – "THE TIME LIMIT FOR FILING HAS EXPIRED"; and 719 – "PER RULE 133.20, A MEDICAL BILL SHALL NOT BE SUBMITTED LATER THAN THE 95TH DAY AFTER THE DATE OF SERVICE."

   28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   The disputed date of service is September 27, 2013. Review of the submitted information finds sufficient documentation to support, by a preponderance of the evidence, that the provider mailed the medical bill to the correct claims address—matching the insurance carrier's claims filing address listed on the explanations of benefits—on November 12, 2013. This date is within 95 days from the date the services were provided. Consequently, the Division finds that the health care provider has fulfilled the timely filing requirements of Rule 133.20. The insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed for reimbursement in accordance with applicable Division rules and fee guidelines.

2. This dispute involves outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $6,330.00. Accordingly, the facility's total billed charges shall be reduced by this amount when calculating outlier payments.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules, which

are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Per Medicare policy, procedure code 96360 may not be reported with procedure codes 29807, 29826, and 23700 billed on the same claim. Payment for this service is included in the reimbursement for the other services. Separate payment is not recommended.
- Procedure code 96361 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $27.01. This amount multiplied by 60% yields an unadjusted labor-related amount of $16.21. This amount multiplied by the annual wage index for this facility of 0.9675 yields an adjusted labor-related amount of $15.68. The non-labor related portion is 40% of the APC rate or $10.80. The sum of the labor and non-labor related amounts is $26.48. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $26.48. This amount multiplied by 130% yields a MAR of $34.42.
- Procedure code C1762 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.63. 125% of this amount is $14.54
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $10.69. 125% of this amount is $13.36
- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75
- Procedure code 29807 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $3,880.22. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,328.13. This amount multiplied by the annual wage index for this facility of 0.9675 yields an adjusted labor-related amount of $2,252.47. The non-labor related portion is 40% of the APC rate or $1,552.09. The sum of the labor and non-labor related amounts is $3,804.56. Per 42 Code of Federal Regulations §419.43(d) and *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.198. This ratio multiplied by the billed charge of $23,281.30

yields a cost of $4,609.70. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $3,804.56 divided by the sum of all APC payments is 77.41%. The sum of all packaged costs is $8,382.62. The allocated portion of packaged costs is $6,488.84. This amount added to the service cost yields a total cost of $11,098.54. The cost of these services exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $4,440.56. 50% of this amount is $2,220.28. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $6,024.84. This amount multiplied by 130% yields a MAR of $7,832.29.

- Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $2,111.62. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,266.97. This amount multiplied by the annual wage index for this facility of 0.9675 yields an adjusted labor-related amount of $1,225.79. The non-labor related portion is 40% of the APC rate or $844.65. The sum of the labor and non-labor related amounts is $2,070.44. Per 42 Code of Federal Regulations §419.43(d) and *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.198. This ratio multiplied by the billed charge of $20,680.00 yields a cost of $4,094.64. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $1,035.22 divided by the sum of all APC payments is 21.06%. The sum of all packaged costs is $8,382.62. The allocated portion of packaged costs is $1,765.61. This amount added to the service cost yields a total cost of $5,860.25. The cost of these services exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $4,048.61. 50% of this amount is $2,024.31. The total Medicare facility specific reimbursement amount for this line, including outlier payment and multiple-procedure discount, is $3,059.53. This amount multiplied by 130% yields a MAR of $3,977.39.
- Per Medicare policy, procedure code 23700 may not be reported with procedure code 29807 and 23700 billed on the same claim. Payment for this service is included in the reimbursement for the other services. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, review of the submitted documentation finds that the modifier is not supported. Separate payment is not recommended.
- Procedure code 0232T has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0340, which, per OPPS Addendum A, has a payment rate of $49.64. This amount multiplied by 60% yields an unadjusted labor-related amount of $29.78. This amount multiplied by the annual wage index for this facility of 0.9675 yields an adjusted labor-related amount of $28.81. The non-labor related portion is 40% of the APC rate or $19.86. The sum of the labor and non-labor related amounts is $48.67. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $48.67. This amount multiplied by 130% yields a MAR of $63.27.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0330 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2710 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code J0171 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Per Medicare policy, procedure code 93005 may not be reported with procedure codes 29807, 29826 and 23700 billed on the same claim. Payment for this service is included in the reimbursement for the other services. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, review of the submitted documentation finds that the modifier is not supported. Separate payment is not recommended.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:

   - Procedure code C1762 denotes human connective tissue. This item is listed on the itemized statement as “Ovation Large.” The operative report indicates “Injection of BMA, Ovation, amniotic membrane allograft, left shoulder.” The provider submitted an invoice for an Ovation Large and BMA Centrifuge and Cell Separator. 28 Texas Administrative Code §134.403(b)(2) defines “implantable” as an object or device that is surgically implanted, embedded, inserted, or otherwise applied, and related equipment necessary to operate, program and recharge the implantable. The documentation did not support that these items were implanted in the patient, but were rather used to obtain cells or tissue from the patient’s body that were returned to the patient’s body (an allograft). The submitted documentation did not support that the submitted charges represented a surgically implanted object or device or otherwise met the definition of an implantable in accordance with the rule. Separate reimbursement is not recommended.

   - Procedure code C1713 denotes an implantable anchor/screw for opposing bone-to-bone or soft tissue-to-bone. The medical bill and the itemized statement indicate 3 units. However, 3 units are not supported. Review of the operating report finds that only 2 anchors were documented as implanted. Accordingly, the supported implantables are: "ANCHOR SUTURE BIORAP" as identified in the itemized statement and labeled on the invoice as "BIORAPTOR" with a cost per unit of $422.00 at 2 units, for a total cost of $844.00. The total net invoice amount (exclusive of rebates and discounts) is $844.00.

   The total add-on amount of 10% or $1,000 per billed item add-on (whichever is less, but not to exceed $2,000 in add-on's per admission) is $84.40. The total recommended reimbursement amount for the implantable items is $928.40.

5. The total allowable reimbursement for the services in dispute is $12,867.42. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $12,867.42. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $12,867.42.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $12,867.42 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	December 4, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.